THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: SOAH DOCKET NO. 453-04-0390.M2

August 26, 2003

Re: MDR #: M2-03-1578-01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:
This male claimant suffered pain in his lower back following a work-related accident on ___. He received x-rays, EMG/NCV, and MRI's He has undergone passive and active rehab, chiropractic treatments, and aquatic therapy. He has received medication, and has undergone a work hardening program.

Disputed Services:
Chronic pain management program for 30 days.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that a 30-day chronic pain management program is medically necessary in this case.

Rationale:
The documentation provided presents several of the indicators that would suggest this patient to be an appropriate candidate for a chronic pain management program in accordance with the *AMA Guidelines to Impairment, Fourth Edition*, page 306 and 307. These behaviors appear to be present in this patient:

1. Self-sustaining, self-generating, and self-reinforcing behavior associated with the injury.
2. Poor coping mechanisms that are significantly interfering with his ADL's.
3. Job loss.
4. He is uncertain as to finding and maintaining employment.
5. Suicidal ideation.
6. Social isolation, by choice.
7. Psychological magnification of symptoms.
8. He worries about car insurance instead of getting better, where he is going to find food, or where he is going to get a job.
9. Depression.

All of these indicators are significant enough to justify that this patient is appropriate for a chronic pain program. The only significant indicator that is absent is the Functional Capacity Evaluation that would

help identify between his physical and psychological barriers to his recovery. However, with the weight of the other indicators, it would be appropriate for the patient to undergo a chronic pain program of thirty (30) days, at five days a week for six weeks.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: (512) 804-4011

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on August 26, 2003.

Sincerely,